State Employee Benefits Committee
December 14, 2009, 1:00 p.m.
Tatnall Building, Room 112
Dover, Delaware

The State Employee Benefits Committee met on December 14, 2009 at the Tatnall Building, Room 112, Dover, Delaware. The following Committee members and guests were present:

Ann Visalli, Director, OMB
Brenda Lakeman, OMB, Director, Statewide Benefits
Faith Rentz, OMB, Statewide Benefits
Ann Skeans, Statewide Benefits
Vicki Ford, OMB, Financial Operations
Mike Morfe, AON
Mary Thuresson, OMB, Statewide Benefits
Casey Oravez, OMB, Financial Operations
Michael Matthews, OMB
Andrew Kerber, Department of Justice
Patricia Griffin, Admin. Office of Courts
Russ Larson, Controller General
Steve Kubico, Office of Controller General
Lori Christiansen, Office of Controller General
Henry Smith, DHSS
Julian Woodall, Insurance Office
Nick Adams, State Treasurer's Office
Tom Cook, Acting Secretary of Finance
Kim Vincent, Office of Pensions
Tina Hession, PHRST
Mary Cooke, DOE
Kim Hawkins, City of Dover
Mary Pat Urbanik, U of D
Judy Anderson, DSEA
Timothy Barchak, DSEA
Stephen P. Smith, DSEA, retired
Barbara Jacobs, DSEA, retired
James Testerman, DSEA, retired
James Harrison, DSEA, retired
Joseph Morocco, HMS
Mike North, Aetna
Katherine Impellizzeri, Aetna
Julie Caynor, Aetna
Drew Brancati, BCBSD
Jay Reed, BCBSD
John Kenyon, AFSCME
Andy Chavira, AFSCME
Mike Begatto AFSCME
Karen Valentine AFSCME

Agenda Items Discussed:

Introductions/Sign In

Ms. Visalli called the meeting to order at 1:00 p.m. Those present for public comment were instructed to sign in. Introductions around the room followed.

Approval of Minutes

Ms. Visalli asked for a motion to approve the October 19, 2009 SEBC minutes. Mr. Adams made the motion to approve the minutes and Mr. Smith seconded the motion. The minutes were approved with unanimous voice vote.

Director's Report

Ms. Lakeman stated Flexible Spending Account (FSA) open enrollment closed the end of November. Enrollment was up slightly with 4,086 enrollments in Health Care; 253 in Dependent Care; and both Health Care and Dependent Care enrollment at 535 for a grand total enrollment of 4,874. There were 1,438 participants who chose to obtain the debit card which is about 30 percent of total participation. Participants can choose to request the debit card any time during the year.

The Health Management Request for Proposal (RFP) that is in process is for Wellness and Disease Management, was released December 1 and bid responses are due January 11. There will be additional updates next month.

For the Employee Assistance Program (EAP) RFP, three finalists were identified from the nine who submitted proposals. Interviews will be January 6. A recommendation is anticipated for the January meeting.

Concerning House Bill 199, the committee approved implementation of this legislation at the September 2009 SEBC meeting. This covers separate billing for developmental delay screenings for infants and toddlers at 9, 18 and 30 months. Changes were put into place as of December 1.

Aetna announced an enhanced, expanded Hospice benefit. Members with a 12 month terminal prognosis can now enroll for 12 months in a Hospice program. That increased from six months. The Group Health Program Aetna membership has advantage of this expanded benefit as of January 1, 2010. This enhancement comes following a pilot program that resulted in increased Hospice utilization, decreased acute care admissions and increased satisfaction with the quality of life. Blue Cross has been asked to look at providing the same option.

A COBRA subsidy update was received Friday from the Treasurer's Office and it was confirmed that reimbursement has been received for the 65 percent of the COBRA premium that the state paid for the second and third quarters of 2009, totaling $62,180. Unless extended by the current proposed federal legislation, eligibility for the ARRA COBRA subsidy which pays for 65 percent of the COBRA premium for those individuals who were or become involuntarily terminated from 9/1/08 through 12/31/09 and are eligible for COBRA benefits to begin during that time period will soon expire. Those who elected the subsidy as of the first month available in March of 2009 were no longer eligible for assistance after November 30, 2009 due to the 9 month eligibility period.

Group Health Plan Updates

Concerning upcoming changes that impact the health program as a whole, Ms. Rentz explained Delaware Code (Del. C.), Title 18, Sections 3346 and 3562 require coverage for colorectal screening modalities and empowers the secretary of Health and Social Services to add such modalities upon recommendation of the Delaware Cancer Consortium, based on national guidelines defined by the American College of Gastroenterology in consultation with the American Cancer Society and the United States Preventative Task Force. In accordance with a memo from Secretary Rita Landgraf, Department of Health and Social Services (DHSS) dated September 11, 2009 and a Domestic and Foreign Insurance Bulletin Number 35 dated October 29, 2009 from Department of Insurance Commissioner, Karen Weldin Stewart: the DHSS secretary has issued an update in accordance with the requirements of the Del. C. (as stated above) adding virtual colonoscopy as an approved colorectal screening modality. Accordingly, all contracts for health insurance issued, delivered or renewed in the State of Delaware after December 1, 2009 must include coverage for virtual colonoscopy for colorectal cancer screening.

Last week this was discussed with the State Employee Benefits Advisory Council and there were questions. Upon inquiry, it has been explained that the type of screening modality used for this procedure is a CT scan. Concerning how many might also be required to have a traditional colonoscopy, Blue Cross conducted a pilot program that showed approximately 20 percent of the

individuals who undergo virtual colonoscopy will have pathology found and need to follow-up "traditional" colonoscopy. The policy related to this colorectal screening option will be communicated to all Primary Care Physicians (PCPs), surgeons, oncologists and GI doctors in order that they may use their discretion along with input from the patient as to which test is best for the patient. There is no recommendation to the SEBC at this time; however, the Group Health Insurance Program will adopt virtual colonoscopy for colorectal cancer screening as an approved colorectal screening modality for all plans, effective July 1, 2010. It is estimated the Group Health Program will see increased costs in the first year following the addition of these screenings as a result of increased screenings and higher rates of additional pathology which may be necessary and resulting from members who previously were not following the screening guidelines. Negotiations are in the process with Blue Cross providers to put in place a global fee arrangement which will include a cost for the virtual screening and standard testing. It is anticipated that the global fee arrangements will be in place with multiple providers by July 1. First year additional costs are estimated to be around $244,000.

Other updates pertain to Michelle's Law and Mental Health parity, both federal health legislation first discussed with SEBC in October. These changes will be put into place effective July 1. Work continues with the medical carriers on the estimated costs to the Group Health Program. At this time the estimated costs to implement these two items will be approximately $1M annually.

Health Fund Financials

Fund Equity Report - Vicky Ford (handout)

There was a decline in the November Report balance. The net balance is negative $17.9M. The Claim Liability Adjustment calculated on a quarterly basis increased by $1.5M. Additionally, three bi-weekly payments were made to Medco during November and the fund paid an additional $4M over the previous month in claim payments to Blue Cross.

Ms. Visalli commented the news was not positive but they expect that this will level off again in December. Overall, costs are rising faster than revenue.

First Quarter FY10 Financial Overview – Mike Morfe (handout)

The Fund Equity Report is reported on an as paid basis and captures everything that is paid. The Quarterly Report is done on an incurred basis. Every number on the Fund Equity Report will eventually show up in the Quarterly Report except for Other Revenues (referenced as $245,000 YTD) and Operating Expenses Refunds (referenced as $30,000 YTD). Page one of the Executive Summary reflects a $2.5M deficit. Following Open enrollment there was not much of a shift in plan enrollment. As such, overall patterns are anticipated to be comparable to previous time periods and not be skewed by Open Enrollment changes. Referring to the handout, Mr. Morfe explained the data and charts. PPO claims are running higher; however, timing of weekly claim payments may be a driving factor.

Ms. Visalli expressed this is an on-going process and there are options. A healthier population could mean paying less in claims. They can review claims and negotiate with the carriers and the Prescription Benefit Manager for greater provider discounts and prescription rebates. They need to prepare to close the gap as we move toward next spring. There are statewide money issues.

Group Health Plan FY 2011 Planning Considerations - Mike Morfe (handout)

The objectives for discussion were to review the latest proposed FY 2011 projection and present and discuss considerations to meet the FY 2011 Group Health Program budget.

No one solution will close the gap. Current projections show costs at an eight percent trend. Revised FY 2010 and 2011 initial projections were explained and discussed.

FY 2010 Premium Projections	$498.3M
FY 2010 Fund Surplus/Part D Assignment	$22.7M
FY 2010 total Revenue	$521.0M
FY2010 Projected Expenditures	$521.0M
FY 2010 Surplus/Deficit:	
➥ Revenue minus Expenditures	$0
➥ Premium minus Expenditures	($22.7M)
FY 2011 Expenditure Projections	$570.7M
Estimate Balance Needed for FY2011	**$72.4M All Funds/$48.7M GF** **GF Active $35.6** **GF Retiree - $13.1**

Ms. Visalli noted that sufficient monies were not built in to keep up with the inflation. Options to attain balance and discussion followed.

- Utilize FY2010 & FY2011 Medicare Part D Subsidy
- Renegotiate contracts with carriers
- Additional controls to keep employees healthy via structured wellness and disease management
- Benefit Plan Design Changes, e.g., increase co-pays, coinsurance, etc.
- Adjust employee contributions
- All of the above

Mr. Larson asked what the trend had been based on and Mr. Morfe noted that long term inflation and market place trend over four to five years expressed a six to eight percent range. Now the market place is seeing seven to ten percent trend. Mr. Larson asked why we are seeing an increase of almost double. Mr. Morfe explained that more work will be done on the underlying claims cost trends over the past two to three years. There was concern over the effectiveness of the Wellness program. Mr. Kubico asked how much of the projected increase for FY 2011 is attributable to the non-state agencies. Ms. Rentz assured him the numbers are small. Mr. Morfe agreed and explained that it is not easy to extract that information from the current analysis and methodology used to project claim expenditures.

Immediate Group Health Program Considerations

Projected FY 2011 Health Fund Shortfall	$72.4M
Utilize Medicare Part D Subsidy Funds	
FY 2010 (Estimate)	($8.5M)
FY 2011 (Estimate)	($8.5M)

Renegotiate Prescription Contract	($7.0M)
Remaining Projected FY 2011 Health Fund Shortfall	$48.4M

Discussion followed. Ms. Visalli noted some things they can do to close the gap. Renegotiations with Medco are estimated to save $7 M which would be used to close the gap. It was explained that the SEBC, per Epilogue language, has authority to move Medicare Part D subsidy monies to OPEB; however, in an effort to close the Health Fund gap, it was being suggested that the subsidy for FY 2010 and 2011, remain in the fund. The committee needs to take action today to secure the subsidy money. If it goes to OPEB it will not offset the current financial problem. There is still the option to move the money into OPEB later if the expenses come down. Mr. Larson had no problem with this use. Questions and answers followed. Mr. Morfe explained even if expenses and projections go down, there will still be some remaining gap to fill for next year. His educated guess is that it is highly unlikely that any operating budget allocation or the options discussed today will close the gap for FY 2011; however, there is an effort to first close the gap with items that don't affect employees.

Ms. Visalli asked for a motion to use Medicare Part D subsidy towards closing the gap for FY11. Controller General Larson made the motion and Mr. Cook seconded the motion. A unanimous voice approval was given and the motion carried.

SEBAC Comment

Ms. Visalli noted Tom Chapman, the new SEBAC Chair, was not present and there was no comment from SEBAC. Ms. Griffin, also a new member to SEBAC, noted that today's meeting issues were discussed at their December meeting.

Public Comments

Steven Smith, President, DSEA Retired and Chair of Coalition of State Retired Employees – They have been reading a lot about the Wellness Program and have conducted some research. They want to share their findings and suggest recommendations. Ms. Visalli appreciated the offer and said they would be contacted.

Bob King, DNREC, AFSCME (not present) – In his absence, his written comments were presented to the SEBC for consideration.

Other Business

Ms. Lakeman stated that at the July 2009 meeting, the SEBC voted to award the FSA and Pre-Tax Commuter Benefit Program to ASI. The recommendation approved was for an initial two year contract. In finalizing the contract, it was discovered that RFP stated the terms of the contract would be an initial three year contract with two, one year optional renewal years. In order to synchronize the RFP, the contract and the SEBC vote for contract award, she asked for a motion from the SEBC revise the SEBC recommendation to award the contract to ASI for three years, beginning January 1, 2010 with two one year optional renewal years. Mr. Adams made the motion and Controller General Larson seconded the motion. A unanimous voice approval followed and the motion carried.

Ms. Lakeman reminded all that 2010 SEBC meetings will be held at 2:00 p.m. Being no further business, Ms. Visalli asked for a motion to adjourn. Mr. Cook made the motion and Mr. Smith seconded the motion. Upon a unanimous voice approval the SEBC adjourned at 1:50 p.m.

Respectfully submitted,

Mary K. Thuresson
Administrative Specialist
Statewide Benefits Office, OMB